

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13404
STATE FILE NUMBER
1632

FILED APR 25 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Frank B. Leitz

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital			Length of stay in 1b 25 Yrs.		d. STREET ADDRESS 20 W. 36th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE LAST FRANK L. SEVERANCE				4. DATE OF DEATH Month Day Year Apr. 5, 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-6-1873		9. AGE (In years last birthday) 84 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant, Kansas			10b. KIND OF BUSINESS OR INDUSTRY City Park Dept.		11. BIRTHPLACE (City and state or country) Scotsville, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Horace W. Severance				14. MOTHER'S MAIDEN NAME Eleanor Ballintine					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 487-16-6674		17. INFORMANT Address Mrs. Watson Green, Overland Park, Ks				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension - Arteriosclerosis Heart disease</u> DUE TO (c) <u>Edema compensation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hyp. Prostate</u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>11 + years</u> <u>7 yrs.</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office, etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>5-2-1946</u> to <u>4-5-57</u> and last saw her alive on <u>4-5-57</u> Death occurred at <u>9:40 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Frank B. Leitz M.D.</u>				22b. ADDRESS <u>1530 Prof Rd, Kansas City Mo</u>		22c. DATE SIGNED <u>4-6-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-8-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Freeman Mortuary Kansas City, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>4-8-57</u>		26. REGISTRAR'S SIGNATURE <u>Neal Minchell</u>			

Mr. Frank Hering
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STATEMENT BY LICENSED EMBALMER



I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed.....
J. H. Freeman

Licensed Embalmer No. *29*

P. O. Address *F.O.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.